GEORGIA DEPARTMENT OF COMMUNITY HEALTH
State Health Benefit Plan
P. O. Box 1990, Atlanta, GA 30301
866-828-4796 (Secure FAX)
Direct Pay Enrollment/Change Form

Please read the Terms, Conditions and Instructions on the back of this form prior to completing the form.

I. Member Identification SSN ____ ____ ____-____ ____-____ ____ ____ ____ ☐ Male ☐ Female Date of Birth ____/ _____ /_____

Last Name _____ First _____ Middle Initial _____ Telephone No. ____/_____/_____

Street Address _____ Apt/Box/Route _____

City _____ State _____ Zip Code (5 digits) _____

II. Type of Action: ☐ Enrollment ☐ Change of Coverage* ☐ Miscellaneous Data Update ☐ Name Change From_____

☐ 11 Direct Payee ☐ 15 Direct Pay Legislator ☐ 12 Surviving Spouse ☐ 16 Other ☐ 29 Extension of 11 Month through COBRA

III. COVERAGE OPTION *Changes are allowed only if you have experienced a Qualifying Event (QE). If you have not experienced a QE you will be enrolled in your current option and tier)

A. Select Vendor: ☐**CIGNA** ☐**UNITEDHEALTHCARE**

B. Select option for members with Medicare Part B: ☐ **MA PPO Standard** ☐ **MA PPO Premium**

C. Select Option for family members not eligible for MA Options: ☐ **HRA** ☐ **HDHP** ☐ **HMO Note: If you or your dependent(s) 65 or older are not enrolled in a MA PPO or split option, you will pay 100% of the cost of the coverage**

Acronyms: HRA (Health Reimbursement Arrangement), HDHP (High Deductible Health Plan), And HMO (Health Maintenance Organization)

Note: If you or a covered dependent will be enrolling in the Medicare Advantage Plan, please send a copy of the Medicare Card(s) for that individual and include the social security number of our retiree. You may fax to the secure fax #: 866-828-4796.

IV. You must answer the following questions unless you and your dependents will be in a Medicare Advantage or split option:

A. Tobacco Surcharge Questions:

Have you or any of your covered dependents used any tobacco products in the previous 60 days?

☐ Yes - Tobacco surcharge will apply ☐ No – Surcharge will NOT apply

B. Spousal Surcharge Questions: (answer only if your spouse is selected for coverage)

#1: Is your spouse eligible for health benefits coverage through his/her employment? ☐ Yes – Answer Spouse Question #2 ☐ No – No Surcharge-skip to section VI

#2: If your spouse enrolled in health benefit coverage through his/her employment? ☐ Yes – No Surcharge, skip to Section VI ☐ No – Answer Spouse Question #3

#3: If your spouse eligible for SHBP coverage through his/her employment? ☐ Yes – Surcharge will NOT apply ☐ No – Spousal Surcharge will apply

NOTE: Please see reverse side of form for details regarding removal of surcharge(s).

V. Coverage Tier - Choose one of the options below - Acronyms: Tobacco (Tob) Spouse (Sp) Surcharge (SC)

☐10 You	☐90 You + Sp	☐94 You + Child(ren)	☐96 You + Family
☐40 You + Tob SC	☐91 You + Sp + Tob SC	☐95 You + Child(ren) + Tob SC	☐97 You + Family + Tob SC
	☐92 You + Sp + Sp SC		☐ 98 You + Family + Sp SC
	☐93 You + Sp + Tob + Sp SC		☐ 99 You + Family + Tob SC + Sp SC

VI. Dependents (Complete only if you have dependent coverage. See reverse side of this form for dependent eligibility requirements. Coverage for each dependent requires submission of additional documents and coverage will not be updated until documentation is received and approved. Use the abbreviations provided to show the relationship of each dependent: **SP for your wife or husband NC for your natural or adopted child SC for your stepchild LC for Legal Guardianship**

Select the Action: A to Add C to Correct D to Delete

Action (Circle)	Full name of spouse or eligible dependent(s) to be covered	Relationship (Circle)	Sex (Circle)	Date of Birth MO/DA/CCYR	Social Security Number **(Required)** DO NOT HOLD FORM
A C D	_____ Last Name First Initial	SP NC SC LC	M F	_____/_____/_____	__ __ __ - __ __ - __ __ __ __
A C D	_____ Last Name First Initial	SP NC SC LC	M F	_____/_____/_____	__ __ __ - __ __ - __ __ __ __
A C D	_____ Last Name First Initial	SP NC SC LC	M F	_____/_____/_____	__ __ __ - __ __ - __ __ __ __
A C D	_____ Last Name First Initial	SP NC SC LC	M F	_____/_____/_____	__ __ __ - __ __ - __ __ __ __

(If adding a dependent, SHBP is now required to collect the Social Security Number. For dependents under age two, SHBP will provide coverage without the social security number upon receipt and approval of SHBP acceptable documentation.

VII. Attestation: I have read and agree to abide by the Terms, Conditions, Authorization and Instructions provided on the back of this form. I do hereby attest that the above information is true and correct to the best of my knowledge. I further acknowledge and understand that I may be subject to a fine of not more than $1,000 or imprisonment for not less than one and no more than five years, or both, if I knowingly and willfully make false or fraudulent statements or representation to the Department regarding the information reported on this form or other information pursuant to O.C.G.A. Section 16-10-20.

Signature of Employee: _____ **Date**: _____

TERMS, CONDITIONS, AUTHORIZATION, AND INSTRUCTIONS

General Information: Please review all State Health Benefit Plan (SHBP) communications and materials prior to completion of this form. Plan information is available on the SHBP web site at www.dch.georgia.gov/shbp. It is essential that you carefully read all your materials and answer all the surcharge questions. Failure to do so could have a financial impact on your premiums.

This form is to be used for the following reasons:
- Enroll in coverage on direct pay basis
- For members already paying premiums on a direct pay basis to change options, tier or to update personal information

You should read this side of the form and then complete Sections I, III, IV, V and Section VI if covering dependent(s). Incomplete forms **will not** be returned for completion. Read the Attestation in Section VII carefully, then sign and date the form. The effective date of coverage is dependent upon the hire date and your payroll deduction for coverage. Refunds can not be issued for incorrect or incomplete information. You will be bound to the Coverage Tier and Option selected and based on answers to surcharge questions.

Enrollment for Coverage: Enrollment for coverage or Change in Option or Tier is limited to the annual Open Enrollment Period, except under limited qualifying events. A detailed list of the events and documentation that is required is provided in the SHBP Summary Plan Documents which are posted at www.dch.georgia.gov/shbp. Coverage for enrollment will be effective the first day of the month following a full month of employment.

Surcharge Questions:
Spousal Surcharge – will be added to your monthly premium if you elect to cover your spouse who is eligible for coverage through his/her employment but chose not to take it. If your spouse is eligible for coverage with SHBP through his/her employment, the spousal surcharge will be waived, provided you answer the surcharge questions. If you fail to answer all of the applicable surcharge questions you will automatically be charged the surcharge until the next Plan Year.
Tobacco Surcharge – A surcharge will be added to your monthly premium if you or any of your covered dependent(s) have used tobacco products in the previous 60 days. This includes dipping, chewing, smoking, etc .If any covered member of your family is unable to achieve tobacco-free status due to a medical condition , you must submit a letter from the treating physician and complete and alternative program in order to prevent imposition of the tobacco surcharge or remove the tobacco surcharge.

How to Remove Surcharge: See Instructions on the SHBP website www.dch.georgia.gov/shbp under the Additional Health Plan Information. The change in premiums will be effective based on the payroll deduction schedule of your employer. No refund in premiums will be made for previous health deductions that included the surcharge amounts. IRS rules do not allow premium changes to be made retroactively.

Eligible Dependents: Be sure to circle the proper code in Section VI to describe the dependent's relationship to you. The following describes the dependents that are eligible and the documentation requirements for each.
A) SP – Your legal Spouse as defined by Georgia law – Copy of certified marriage license or copy of your most recent Federal Tax Return (filed jointly with spouse) including legible signatures for you and your spouse with financial information blacked out. The spouse's social security number is required.
B) NC – Your Natural or Adopted Child – Copy of Birth Certificate showing parents names. (Confirmation of birth issued by hospital for New Born is accepted)
C) SC – Step Child – Copy of Birth Certificate showing spouse as parent AND a copy of certified marriage license for yourself and
D) LC – Legal Guardianship Other Child which includes adoptions and temporary and permanent guardianship – Copy of court decree showing your financial responsibility for the dependent; AND copy of certified birth certificate.
E) Children meeting the requirements listed above are eligible for coverage until the end of the month in which they turn 26. Coverage for a Disabled Child can be continued beyond age 26 if medical documentation is submitted to SHBP which meets SHBP disability requirements. The child must have been disabled before age 26.
NOTE: Dependents will not be verified as having coverage until documentation and the social security number for each dependent (new federal law requirement) has been received and entered. . For dependents under age two, SHBP will provide coverage without the social security number upon receipt and approval of SHBP acceptable documentation.

Penalties for Misrepresentation – If a SHBP participant misrepresents eligibility information when applying for coverage, during a change of coverage or when filling for benefits, the SHBP may take adverse action against the participant, including but not limited to termination of coverage (for the participant and his or her dependents(s) or imposing liability to the SHBP for fraud or indemnification (requiring payment for benefits to which the participant or his/her beneficiaries were not entitled). Penalties may include a lawsuit, which may result in payment of charges to the Plan or criminal prosecution in a court of law. In order to avoid enforcement of the penalties, the participant must notify the SHBP immediately if a dependent is no longer eligible for coverage or if the participant has questions or reservations about the eligibility of a dependent. This policy may be enforced to the fullest extent of the law. Intentional misrepresentation in response to surcharge questions will have significant consequences. You and your covered dependent(s) will automatically lose SHBP coverage for 12 months beginning on the date that your false response is discovered.

Authorization: I have read and agree to abide by the Terms, Conditions, and Instructions provided on this form. I hereby authorize my employer to deduct each month from any wages due me the premium amount and any applicable surcharges for the coverage I have selected. I understand that the selected coverage will be effective the first of the month following the appropriate deduction. I also understand that I cannot change or cancel coverage until the next Open Enrollment Period except under limited conditions. I understand that if I terminate my employment and I am rehired during the same Plan Year, SHBP regulations require that I maintain the same option. I understand that if I fail to answer a question(s) concerning one of the surcharges, I will automatically be charged the applicable surcharge. Surcharges will apply until the next plan year or until I complete the surcharge removal process. I hereby certify that the above information and any supporting document(s) are true and correct. I understand that misrepresentation or falsification will subject me to penalties and possible legal action.